


# Screening Centers

## Provider Manual



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## CHAPTER III. PROVIDER-SPECIFIC POLICIES

### A. ELIGIBILITY OF SCREENING CENTERS

Agencies wishing to participate as health screening centers in the Medicaid program should direct their request for vendor number to the Iowa Medicaid Enterprise (IME) Provider Services Unit. In order to be accepted for participation, each screening center must meet quality standards and continuity of care consistent with guidelines established by the Iowa Department of Public Health (IDPH).

### B. COVERAGE OF SERVICES

#### 1. Care Coordination


This service is reimbursed by the IDPH through a contract with the Department of Human Services (DHS).

**NOTE:** The Centers for Medicare and Medicaid Services (CMS) policy states, "payments for allowable Medicaid services must not duplicate payments that have been, or should have been, included as part of a **direct** medical service. Activities that are considered integral to, or an extension of, the specified covered service are included in the rate set for the direct service, therefore they should not be claimed as another service. For example, when an agency provides a medical service, the practitioner should not bill separately for the cost of a referral. These activities are properly paid for as part of the medical service."

If the family needs a service that is not covered by Medicaid, make a good-faith effort to locate providers who will furnish those services.

#### 2. Interpreter Services

Interpretative services may be covered, whether done orally or through sign language. Interpreters must provide only interpretation services for the agency. The services must facilitate access to Medicaid covered services.

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In order for interpretation services to be covered by Iowa Medicaid, the services must meet the following criteria:

- ◆ Provided by interpreters who provide only interpretive services
- ◆ Interpreters may be employed or contracted by the billing provider
- ◆ The interpretive services must facilitate access to Medicaid covered services

Providers may only bill for these services if offered in conjunction with an otherwise Medicaid covered service. Medical staff that are bilingual are not reimbursed for the interpretation but only for their medical services.

#### **a. Documentation of the Service**

The billing provider must document in the member's record the:


- ◆ Interpreter's name or company,
- ◆ Date and time of the interpretation,
- ◆ Service duration (time in and time out), and
- ◆ Cost of providing the service.

#### **b. Qualifications**

It is the responsibility of the billing provider to determine the interpreter's competency. Sign language interpreters should be licensed pursuant to 645 IAC 361. Oral interpreters should be guided by the standards developed by the [National Council on Interpreting in Health Care](#).

Following is the instruction for billing interpretive services when that service is provided by an outside commercial translation service:

- ◆ Bill code T1013
  - For telephonic interpretive services use modifier "UC" to indicate that the payment should be made at a per-minute unit.
  - The lack of the UC modifier will indicate that the charge is being made for the 15 minute face-to-face unit.
- ◆ Enter the number of minutes actually used for the provision of the service. The 15 minute unit should be rounded up if the service is provided for 8 minutes or more.

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**NOTE:** Because the same code is being used but a conditional modifier may be necessary, any claim where the UC modifier is **NOT** used and the units exceed 24 will be paid at 24 units.

### 3. Nutritional Counseling

Screening centers are eligible for reimbursement of nutritional counseling (medical nutritional therapy) services provided by licensed dietitians who are employed by or have contracts with the provider when a nutritional problem or a condition of such severity exists that nutritional counseling beyond that which is normally expected as part of the standard medical management is warranted.

Medical conditions that can be referred to a licensed dietitian include the following:

#### ◆ Inadequate or excessive growth

Examples include:

- Failure to thrive,
- Undesired weight loss,
- Underweight,
- Excessive increase in weight relative to linear growth,
- Major changes in weight-to-height percentile or Body Mass Index (BMI) for the child's age;
- Excessive appetite, or
- Hyperphagia.

#### ◆ Inadequate dietary intake

Examples include:


- Formula intolerance,
- Food allergy,
- Limited variety of foods,
- Limited food resources, and
- Poor appetite.

#### ◆ Infant or child feeding problems

Examples include:

- Poor suck or swallow,
- Breastfeeding difficulties,
- Lack of developmental feeding progress,



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- Inappropriate kinds or amounts of feeding offered,
- Limited information or skills of caregiver,
- Food aversions enteral or parenteral feeding, and
- Delayed oral motor skills.

♦ **Chronic disease requiring nutritional intervention**

Examples include:

- Congenital heart disease,
- Pulmonary disease,
- Renal disease,
- Cystic fibrosis,
- Metabolic disorder,
- Diabetes,
- Gastrointestinal disease, and
- Any other genetic disorders requiring nutritional intervention.

♦ **Medical conditions requiring nutritional intervention**

Examples include:

- Iron deficiency anemia,
- High serum lead level,
- Familial hyperlipidemia,
- Hyperlipidemia, and
- Pregnancy.

♦ **Developmental disability**

Examples include:

- Increased risk of altered energy and nutrient needs,
- Oral-motor or behavioral feeding difficulties,
- Medication-nutrient interaction, and
- Tube feedings.

♦ **Psychosocial factors**

Examples include behaviors suggesting an eating disorder. Children with an eating disorder should also be referred to community resources and to their primary care provider for evaluation and treatment.

This is not an all-inclusive list. Other diagnoses may be appropriate and warrant referral to a licensed dietitian.



## Individual Nutrition Evaluation and Assessment

Initial evaluations and follow-up assessments document the process of comprehensive data collection, child and family observation, and analysis to determine a child's nutritional status in order to develop a plan of care. The evaluation is based on:

- ◆ Informed clinical opinion through objective food record review,
- ◆ Evaluation of the child's pattern of growth, and
- ◆ Evaluation of area of concern based on the evaluation tool used and medical nutritional therapy.

### 4. Screening Examinations


Screening centers will be paid for health screening examinations for Medicaid members who are under 21 years of age.

The recommended schedule for health, vision, and hearing screening is as follows:

Child's Age	Number of Screenings Recommended	Recommended Ages for Screening
0 to 12 months	7	2-3 days,* 1, 2, 4, 6, 9, and 12 months
13 to 24 months	3	15, 18, and 24 months
3 to 6 years	4	3, 4, 5, and 6 years
7 to 20 years	7	8, 10, 12, 14, 16, 18, and 20 years
* For newborns discharged in 24 hours or less after delivery.		

The periodicity schedule provides a minimum basis for follow-up examinations at critical points in a child's life. Families who accept screening will receive a notice that screening is due 60 days before the recommended ages for screening. New eligibles will receive a notice that screening is due immediately and then notified according to the recommended ages.

Interperiodic screening, diagnosis, and treatment allow the flexibility necessary to strengthen the preventative nature of the program. Interperiodic screens may be obtained as required by foster care, educational standards, or when requested for a child.

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These recommendations for preventive health care of children and youth represent a guide for the care of well children who receive competent parenting, who have not manifested any important health problems, and who are growing and developing satisfactorily. Other circumstances may indicate the need for additional visits or procedures.

If children or youth come under care for the first time at any point on the schedule, or if any of the items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest time.

Click [here](#) to view RC-0080, *Screening Components by Age*, online.

## 5. Transportation Services to Receive Medical Care


To help ensure that Medicaid members have access to medical care within the scope of the program, the Department will arrange non-emergency medical transportation (NEMT) or reimburse the member under certain conditions for transportation costs to receive necessary medical care. This will be facilitated through the broker designated by the Department.

When a member needs transportation or reimbursement for transportation, the member must contact the broker 72 business hours in advance for approval and scheduling. Modes of transportation may include:

- ◆ Bus tokens,
- ◆ Volunteer services,
- ◆ Mileage reimbursement, or
- ◆ Other forms of public transportation.

The IME has contracted NEMT services through TMS Management Group, Inc. For information about the broker's policies and processes, please visit their website: <http://tmsmanagementgroup.com/index.php/iowa-medicaid-net-program/>.

Screening centers are eligible for reimbursement of non-emergency medical transportation when they have contracted for or provide the transportation. The transportation must be to a Medicaid-enrolled provider for a Medicaid covered service to be eligible for reimbursement. Transportation should be in compliance with state laws (i.e., child restraint seats) and the most appropriate for the circumstances of the family. Maintain documentation of transportation services.


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## C. CONTENT OF WELL CHILD EXAMINATION

A well child examination must include at least the following:

- ◆ Comprehensive health and developmental history, including an assessment of both physical and mental health development. This includes:
  - A developmental assessment.
  - An assessment of nutritional status.
- ◆ A comprehensive unclothed physical examination. This includes:
  - Physical growth.
  - A physical inspection, including ear, nose, mouth, throat, teeth, and all organ systems, such as pulmonary, cardiac, and gastrointestinal.
- ◆ Appropriate immunizations according to age and health history as recommended by the Iowa Department of Public Health.
- ◆ Health education, including anticipatory guidance.
- ◆ Hearing and vision screening.
- ◆ Appropriate laboratory tests. These shall include:
  - Hematocrit or hemoglobin
  - Lead toxicity screening for all children ages 12 to 72 months
  - Tuberculin test, when appropriate
  - Hemoglobinopathy, when appropriate
  - Serology, when appropriate
- ◆ Oral health assessment with dental referral for children over age 12 months and older based on risk assessment.

Click [here](#) to view the Iowa Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT) Care for Kids Health Maintenance Recommendations for additional details.

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## 1. History and Guidance

### a. Comprehensive Health and Developmental History

A comprehensive health and developmental history is a profile of the member's medical history. It includes an assessment of both physical and mental health development. Take the member's medical history from the member, if age-appropriate, or from a parent, guardian, or responsible adult who is familiar with the member's history.

Complete or update a comprehensive health and developmental history at every initial or periodic EPSDT screening visit. Include the following:

- ◆ Identification of specific concerns
- ◆ Family history of illnesses
- ◆ The member's history of illnesses, diseases, allergies, and accidents
- ◆ Information about the member's social or physical environment that may affect the member's overall health
- ◆ Information on current medications or adverse reaction or responses due to medications
- ◆ Immunization history
- ◆ Developmental history to determine whether development falls within a normal range of achievement according to age group and cultural background
- ◆ Identification of health resources currently used

### b. Developmental Screening

Screening is a "brief assessment procedure designed to identify children who should receive more intensive diagnosis or assessment." The primary purpose of **developmental screening** is to identify children who may need more comprehensive evaluation.

The use of validated screening tools improves detection of problems at the earliest possible age. Each developmental screening instrument is accompanied by an interpretation and report (e.g., a score or designation as normal or abnormal). Any interventions or referrals based on abnormal findings should be documented as well.



Developmental screening for young children should include the following four areas:


- ◆ Speech and language
- ◆ Fine and gross motor skills
- ◆ Cognitive skills
- ◆ Social and emotional behavior

In screening children from birth to six years of age, it is recommended that recognized instruments are selected. The best instruments have good psychometric properties, including adequate sensitivity, specificity, validity, and reliability, and have been standardized on diverse populations.

Parents report instruments such as the *Parents' Evaluation of Developmental Status* (PEDS), *Ages and Stages Questionnaires*, and the *Child Development Review* have excellent psychometric properties and require a minimum of time.

No list of specific instruments is required for identifying developmental problems of older children and adolescents. However, the following principles should be considered in developmental screening:

- ◆ Collect information on the child's or adolescent's usual functioning, as reported by the child, parents, teacher, health professional or other familiar person.
- ◆ Incorporate and review this information in conjunction with other information gathered during the physical examination.
- ◆ Make an objective professional judgment as to whether the child is within the expected ranges. Review the developmental progress of the child as a component of overall health and well-being, given the child's age and culture.
- ◆ Screening should be culturally sensitive and valid. Do not dismiss or excuse potential problems improperly based on culturally appropriate behavior. Do not initiate referrals improperly for factors associated with cultural heritage.
- ◆ Screening should not result in a label or premature diagnosis being assigned to a child. Report only that a condition was referred or that diagnostic treatment services are needed. Results of initial screening should not be accepted as conclusions and do not represent diagnosis.

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When the provider or the parent has concerns or questions regarding the functioning of the child in relation to expected ranges of activities after screening, make referral for developmental assessment by professionals trained in the use of more elaborate instruments and structured tests.

**Developmental surveillance** is different than developmental testing. Developmental surveillance is a flexible, continuous process in which knowledgeable professionals perform skilled observations of children during the provision of health care.


Developmental surveillance is an important technique, which includes questions about the development as a part of the general developmental survey or history. It is not a “test” as such, and is not billable as a developmental screen.

Health care providers often use age-appropriate developmental checklists to record milestones during preventative care visits as part of developmental surveillance. Click [here](#) to view the surveillance tool for children from birth through age 20, with the *Iowa Child Health and Developmental Record* (CHDR).

The adolescent population presents a different developmental challenge. Many of the more readily apparent developmental problems should have been identified and be under treatment. Focus screening on such areas of special concern as potential presence of learning disabilities, peer relations, psychological or psychiatric problems, and vocational skills.

For further information on developmental screening, see:

- ◆ [Care for Kids Provider website](#)
- ◆ [Developmental Behavioral Online website of the American Academy of Pediatrics](#)
- ◆ [Assuring Better Child Development and Health \(ABCD\) Electronic Resource Center of the National Academy for State Health Policy](#)
- ◆ [National Center of Home Initiatives for Children with Special Needs website of the American Academy of Pediatrics](#)

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### c. Health Education/Anticipatory Guidance

Health education that includes anticipatory guidance is an essential component of screening services. Provide it to parents and youth (if age-appropriate) at each screening visit. Design it to:

- ◆ Assist the parents and youth in understanding what to expect in terms of the child's development.
- ◆ Provide information about the benefits of healthy lifestyles and practices as well as injury and disease prevention.

Health education must be age-appropriate, culturally competent, and geared to the particular child's medical, developmental, dental, and social circumstances. Four lists of age-related topics recommended for discussion at screenings are included below.

Anticipatory guidance and health education recommended topics are included in the *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, Third Edition, Arlington, VA. This publication is available from the National Center for Education in Maternal and Child Health (703) 356-1964, (888) 434-4MCH, or click [here](#) to view the website.

These lists are guidelines only. They do not require the inclusion of topics that are inappropriate for the child nor limit topics that are appropriate for the child.

#### **Suggested Health Education Topics: Birth - 18 Months**

##### ***Oral Health***

- |   |   |
|---|---|
| ◆ Appropriate use of bottle and breast feeding                            | ◆ Non-nutritive sucking (thumb, finger, and pacifier)               |
| ◆ Fluoride exposure: toothpaste, water, topical fluoride, and supplements | ◆ Teething and tooth eruption                                       |
| ◆ Infant oral care: cleaning teeth and gums                               | ◆ First dental visit by age one                                     |
| ◆ Early childhood caries/tooth decay                                      | ◆ Feeding and snacking habits: exposure to carbohydrates and sugars |
| ◆ Transmission of oral bacteria   | ◆ Use of cup and sippy cup  |
|   | ◆ Importance of baby teeth  |





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### ***Injury Prevention***

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- ◆ Infant and child CPR
- ◆ Child care options
- ◆ Child safety seat restraint
- ◆ Child safety seats
- ◆ Importance of protective helmets
- ◆ Electric outlets
- ◆ Animals and pets
- ◆ Hot water heater temperature
- ◆ Ingestants, pieces of toys, popcorn, peanuts, hot dogs, powder, plastic bags
- ◆ Exposure to sun and heat
- ◆ Safety locks
- ◆ Lock up chemicals
- ◆ Restricted play areas on the farm
- ◆ Smoke detectors
- ◆ Stairway gates, walkers, cribs
- ◆ Syrup of ipecac, poison control
- ◆ Emergency telephone numbers
- ◆ Water precautions: buckets, tubs, small pools

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### ***Mental Health***

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- ◆ Adjustment to new baby
- ◆ Balancing home, work, and school
- ◆ Caretakers' expectations of infant development
- ◆ Responding to infant distress
- ◆ Baby self-regulation
- ◆ Child care
- ◆ Sibling rivalry
- ◆ Support from spouse and friends
- ◆ Recognizing unique temperament
- ◆ Creating stimulating learning environments
- ◆ Fostering baby caregiver attachment

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### ***Nutrition***

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- ◆ Bottle propping
- ◆ Breast or formula feeding to 1 year
- ◆ Burping
- ◆ Fluid needs
- ◆ Introduction of solid foods 4-6 months
- ◆ Managing meal time behavior
- ◆ Self-feeding
- ◆ Snacks
- ◆ Weaning



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### ***Other Preventive Measures***

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- ◆ Back sleeping
- ◆ Bowel patterns
- ◆ Care of respiratory infections
- ◆ Crying or colic
- ◆ Effects of passive smoking
- ◆ Fever
- ◆ Hiccoughs
- ◆ Importance of well-child visits

### **Suggested Health Education Topics: 2 – 5 Years**

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#### ***Oral Health***

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- ◆ Oral care: parental tooth brushing and flossing when the teeth touch, monthly “lift the lip”
- ◆ Teething and tooth eruption
- ◆ Importance of baby teeth
- ◆ Regular dental visits
- ◆ Non-nutritive sucking (thumb, finger, and pacifier)
- ◆ Feeding and snacking habits: exposure to carbohydrates and sugars
- ◆ Transmission of oral bacteria
- ◆ Appropriate use of bottle and breast feeding
- ◆ Use of sippy cup
- ◆ Use of sugary medications
- ◆ Early childhood carries, gingivitis
- ◆ Dental injury prevention
- ◆ Fluoride exposure: toothpaste, water, topical fluoride, and supplements
- ◆ Sealants on deciduous molars and permanent six-year molars

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#### ***Injury Prevention***

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- ◆ CPR training
- ◆ Booster car seat
- ◆ Burns and fire
- ◆ Farm hazards: manure pits, livestock, corn cribs, grain auger, and grain bins
- ◆ Dangers of accessible chemicals
- ◆ Importance of protective helmets
- ◆ Machinery safety
- ◆ No extra riders on tractor
- ◆ Play equipment
- ◆ Purchase of bicycles
- ◆ Put up warning signs
- ◆ Restricted play areas
- ◆ Street danger
- ◆ Teach child how to get help
- ◆ Toys
- ◆ Tricycles
- ◆ Walking to school
- ◆ Water safety
- ◆ Gun storage



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### ***Mental Health***

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- ◆ Adjustment to increasing activity of child
- ◆ Balancing home, work, and school
- ◆ Helping children feel competent
- ◆ Child care
- ◆ Sibling rivalry
- ◆ Managing emotions

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### ***Nutrition***

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- ◆ Appropriate growth pattern
- ◆ Appropriate intake for age
- ◆ Control issues over food
- ◆ Managing meal-time behavior
- ◆ Physical activity
- ◆ Snacks

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### ***Other Preventive Measures***

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- ◆ Adequate sleep
- ◆ Care of illness
- ◆ Clothing
- ◆ Common habits
- ◆ Importance of preventative health visits
- ◆ Safety rules regarding strangers
- ◆ TV watching
- ◆ Age-appropriate sexuality education
- ◆ School readiness
- ◆ Toilet training
- ◆ Smoke-free environments
- ◆ Social skills

## **Suggested Health Education Topics: 6 – 12 Years**

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### ***Oral Health***

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- ◆ Fluoride exposure: toothpaste, water, topical fluoride, and supplements
- ◆ Oral care: supervised tooth brushing and flossing
- ◆ Gingivitis and tooth decay
- ◆ Non-nutritive sucking (thumb, finger, and pacifier)
- ◆ Permanent tooth eruption
- ◆ Regular dental visits
- ◆ Dental referral: orthodontist
- ◆ Diet and snacking habits: exposure to carbohydrates, sugars, and pop, diet/snack habits and sports drinks
- ◆ Dental injury prevention: mouth guards for sports
- ◆ Sealants on deciduous molars and permanent 6- and 12-year molars
- ◆ Smoking and smokeless tobacco



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### ***Injury Prevention***

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- ◆ Bicycle (helmet) safety
- ◆ Car safety
- ◆ CPR training
- ◆ Dangers of ponds and creeks
- ◆ Electric fences
- ◆ Farm hazards: corn cribs, grain auger, gravity flow wagon, livestock
- ◆ Fire safety
- ◆ Gun and hunter safety
- ◆ Emergency telephone numbers
- ◆ Machinery safety
- ◆ Mowing safety
- ◆ Self-protection tips
- ◆ Sports safety
- ◆ Street safety
- ◆ Tractor safety training
- ◆ Water safety
- ◆ High noise levels

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### ***Mental Health***

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- ◆ Discipline
- ◆ Emotional, physical, and sexual development
- ◆ Handling conflict
- ◆ Positive family problem solving
- ◆ Developing self esteem
- ◆ Nurturing friendships
- ◆ Peer pressure and adjustment
- ◆ School-related concerns
- ◆ Sibling rivalry

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### ***Nutrition***

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- ◆ Appropriate intake for age
- ◆ Breakfast
- ◆ Child involvement with food decisions
- ◆ Food groups
- ◆ Inappropriate dietary behavior
- ◆ Managing meal time behavior
- ◆ Peer influence
- ◆ Physical activity
- ◆ Snacks

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### ***Other Preventive Measures***

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- ◆ Adequate sleep
- ◆ Clothing
- ◆ Exercise
- ◆ Hygiene
- ◆ Importance of preventative health visits
- ◆ Smoke-free environments
- ◆ Safety regarding strangers
- ◆ Age-appropriate sexuality education
- ◆ Social skills
- ◆ Preparation of girls for menarche
- ◆ Sports
- ◆ Stress
- ◆ TV viewing



## **Suggested Health Education Topics: 13 – 21 Years**

### ***Oral Health***

- ◆ Fluoride exposure: toothpaste, water and topical fluoride
- ◆ Daily oral care: tooth brushing and flossing
- ◆ Gingivitis, periodontal disease, and tooth decay
- ◆ Permanent tooth eruption
- ◆ Regular dental visits
- ◆ Dental referral: orthodontist and oral surgeon for third molars
- ◆ Diet and snacking habits: exposure to carbohydrates, sugars, sports drinks, and pop
- ◆ Dental injury prevention: Mouth guards for sports
- ◆ Sealants on premolars and permanent 6- and 12-year molars
- ◆ Smoking and smokeless tobacco
- ◆ Drug use (methamphetamines)
- ◆ Oral piercing

### ***Development***

- ◆ Normal biopsychosocial changes of adolescence

### ***Gender Specific Health***

- ◆ Abstinence education
- ◆ Contraception, condom use
- ◆ HIV counseling or referral
- ◆ Self-breast exam
- ◆ Self-testicular exam
- ◆ Sexual abuse, date rape
- ◆ Gender-specific sexual development
- ◆ Sexual orientation
- ◆ Sexual responsibility, decision making
- ◆ Sexually transmitted diseases
- ◆ Unintended pregnancy

### ***Health Member Issues***

- ◆ Selection and purchase of health devices or items
- ◆ Selection and use of health services



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### ***Injury Prevention***

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- ◆ CPR and first aid training
- ◆ Dangers of farm ponds and creeks
- ◆ Falls
- ◆ Firearm safety, hunting practices
- ◆ Gun and hunter safety
- ◆ Handling agricultural chemicals
- ◆ Hearing conservation
- ◆ Machinery safety
- ◆ Motorized vehicle safety (ATV, moped, motorcycle, car, and trucks)
- ◆ Overexposure to sun
- ◆ ROPS (roll over protective structure)
- ◆ Seat belt usage
- ◆ Helmet usage
- ◆ Smoke detector
- ◆ Sports recreation, workshop laboratory, job, or home injury prevention
- ◆ Tanning practices
- ◆ Violent behavior
- ◆ Water safety
- ◆ High noise levels

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### ***Nutrition***

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- ◆ Body image, weight issues
- ◆ Caloric requirements by age and gender
- ◆ Balanced diet to meet needs of growth
- ◆ Exercise, sports, and fitness
- ◆ Food fads, snacks, fast foods
- ◆ Selection of fitness program by need, age, and gender
- ◆ Special diets

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### ***Personal Behavior and Relationships***

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- ◆ Communication skills
- ◆ Dating relationships
- ◆ Decision making
- ◆ Seeking help if feeling angry, depressed, hopeless
- ◆ Community involvement
- ◆ Relationships with adults and peers
- ◆ Self-esteem building
- ◆ Stress management and reduction
- ◆ Personal responsibility



### ***Substance Use***

- ◆ Alcohol and drug cessation
- ◆ Counseling or referral for chemical abuse
- ◆ Driving under the influence
- ◆ HIV counseling and referral
- ◆ Riding with intoxicated driver
- ◆ Sharing of drug paraphernalia
- ◆ Steroid or steroid-like use
- ◆ Tobacco cessation

### ***Other Prevention Measures***

- ◆ Adequate sleep
- ◆ Clothing
- ◆ Exercise
- ◆ Hygiene
- ◆ Importance of preventative health visits
- ◆ Smoke-free environments
- ◆ Safety regarding strangers
- ◆ Age-appropriate sexuality education
- ◆ Social skills
- ◆ Preparation of girls for menarche
- ◆ Sports
- ◆ Stress
- ◆ TV viewing

#### **d. Mental Health Assessment**

Mental health assessment should capture important and relevant information about the child as a person. It may include a psychosocial history such as:

- ◆ The child's **life-style**, home situation, and "significant others."
- ◆ A **typical day**: How the child spends the time from getting up to going to bed.
- ◆ **Religious and health beliefs** of the family relevant to perceptions of wellness, illness, and treatment, and the child's outlook on the future.
- ◆ **Sleep**: Amount and patterns during day and at night; bedtime routines; type and location of bed; and nightmare, terrors, and somnambulating.
- ◆ **Toileting**: Methods of training used, when bladder and bowel control attained, occurrence of accidents or of enuresis or encopresis, and parental attitudes.



- ◆ **Speech:** Hesitation, stuttering, baby talk, lisping, and estimate of number of words in vocabulary.
- ◆ **Habits:** Bed rocking, head banging, tics, thumb sucking, pica, ritualistic behavior, and use of tobacco, alcohol, or drugs.
- ◆ **Discipline:** Parental assessment of child's temperament and response to discipline, methods used and their success or failure, negativism, temper tantrums, withdraw, and aggressive behavior.
- ◆ **Schooling:** Experience with day care, nursery school, and kindergarten; age and adjustment on entry; current parental and child satisfaction; academic achievement; and school's concerns.
- ◆ **Sexuality:** Relations with members of the opposite sex; inquisitiveness regarding conception, pregnancy, and girl-boy differences; parental responses to child's questions and the sex education parents have offered regarding masturbation, menstruation, nocturnal emissions, development of secondary sexual characteristics, and sexual urges; and dating patterns.
- ◆ **Personality:** Degree of independence; relationship with parents, siblings, and peers; group and independent activities and interests, congeniality; special friends (real or imaginary); major assets and skills; and self-image.


**Source:** Boyle Jr., W.E. and Hoekelman, R.A. *The Pediatric History*, In Hoekelman, R.A. ed. Primary Pediatric Care, Fourth Edition, 2001.

Clinical screening tools can increase the identification of psychosocial problems and mental disorders in primary care settings. Moreover, such tools can provide an important framework for discussing psychosocial issues with families. These screening tools can be grouped into three general categories:

- ◆ Broad psychosocial tools that assess:
  - Overall functioning, family history, and environmental factors;
  - Deal with a wide range of psychosocial problems; and
  - Identify various issues for discussion with the child or adolescent and family.

An example of this type of tool is the *Pediatric Intake Form*, which can be used to assess such issues as parental depression and substance use, gun availability, and domestic violence (Kemper and Kelleher, 1996a, 1996b).



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- ◆ Tools that provide a general screen for psychosocial problems or risk in children and adolescents, such as the *Pediatric Symptom Checklist* (Jellinek et al., 1998, 1999).
- ◆ Tools that screen for specific problems, symptoms, and disorders, such as the *Conner's Rating Scales for ADHD* (Conners, 1997) and the *Children's Depression Inventory* (Kovacs, 1992).

Often a broader measure such as the *Pediatric Symptom Checklist* is used first, followed by a more specific tool focused on the predominant symptoms for those that screen positive on the broader measure.

Some of the more specific tools may not be readily available to primary care health professionals or may require specialized training.

**Source:** Jellinek M, Patel BP, Froehle MC, eds. 2002. *Bright Futures in Practice: Mental Health – Volume I. Practice Guide*. Arlington, VA: National Center for Education in Maternal and Child Health.

Click [here](#) to view the *Pediatric Symptom Checklist*.

## 2. Laboratory Tests


### a. Cervical Papanicolaou (PAP) Smear

Regular cervical Papanicolaou (PAP) smears are recommended for all females who are sexually active or whose sexual history is thought to be unreliable at age 18. High-risk for cancer in situ are those who:

- ◆ Begin sexual activity in early teen years
- ◆ Have multiple partners

Sexually active females should receive family planning counseling, including PAP smears, self-breast examinations, and education on prevention of sexually-transmitted infections (STI).

Make a referral for further evaluation, diagnosis, or treatment when the smear demonstrates an abnormality. If first smear is unsatisfactory, repeat as soon as possible.

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## b. Chlamydia Test

Routine testing of sexually active women for chlamydia trachomatis is recommended for asymptomatic persons at high risk for infection (e.g., age less than 25, multiple sexual partners with multiple sexual contacts). For recent sexual partners of persons with positive tests for STI, also provide:

- ◆ Education on prevention of STI
- ◆ Education on the importance of contraception to prevent pregnancy

## c. Gonorrhea Test

Testing for gonorrhea may be done on persons with:

- ◆ Multiple sexual partners or a sexual partner with multiple contacts
- ◆ Sexual contacts with a person with culture-proven gonorrhea
- ◆ A history of repeated episodes of gonorrhea

Discuss how to use contraceptives and make them available. Offer education on prevention of STIs.

## d. Hemoglobin and Hematocrit

One hematocrit or hemoglobin determination is suggested by the American Academy of Pediatrics during the first year, and in each of the following intervals:

- ◆ 9-12 months, if any of the following risk factors are present:
  - Qualify for EPSDT Care for Kids
  - Low socioeconomic status
  - Birth weight under 1500 grams
  - Whole milk given before 6 months of age (not recommended)
  - Low-iron formula given (not recommended)
- ◆ 11-20 years. Annual screening for females, if any of the following factors are present:
  - Qualify for EPSDT Care for Kids
  - Moderate to heavy menses
  - Chronic weight loss
  - Nutrition deficit
  - Athletic activity



A test for anemia may be performed at any age if there is:

- ◆ Medical indication noted in the physical examination
- ◆ Nutritional history of inadequate iron in the diet
- ◆ History of blood loss
- ◆ Family history of anemia

All children whose hemoglobin or hematocrit is less than the fifth percentile are considered at risk for developing anemia.

Children under five years of age with incomes under 185% of poverty and hemoglobin or hematocrit below the fifth percentile qualify for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

#### **Fifth Percent Criteria for Children**

Age/Years	Hematocrit	Hemoglobin
6 months up to 2 years	32.9	11.0
2 up to 5 years	33.0	11.1
5 up to 8 years	34.5	11.5
8 up to 12 years	35.4	11.9


#### **Female (non-pregnant)**

12 up to 15 years	35.5	11.8
15 up to 18 years	35.9	12.0
18 up to 21 years	35.7	12.0

#### **Male**

12 up to 15 years	37.3	12.5
15 up to 18 years	39.7	13.3
18 up to 21 years	39.9	13.5

**Source:** "Recommendations to Prevent and Control Iron Deficiency in the United States," *Morbidity and Mortality Weekly Report*, April 3, 1998; Vol. 47, No. RR-3, pages 1-29.

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#### e. Hemoglobinopathy Screening

Screen infants not born in Iowa and children of Caribbean, Latin American, Asian, Mediterranean, and African descent who were born before February 1988 for hemoglobin disorders. Identification of carrier status before conception permits genetic counseling and availability of diagnostic testing in the event of pregnancy.

The Hemoglobinopathy Screening and Comprehensive Care Program at the University of Iowa offers testing for a small fee. Call (319) 356-1400 for information.

#### f. Lead Testing


Perform blood lead testing for lead toxicity on children aged 12 to 72 months of age. The goal of all lead poisoning prevention activities is to reduce children's blood lead levels below 10 µg/dL.

Do not use erythrocyte protoporphyrin (EP) as a screening tool for lead poisoning, because it is not sensitive enough to identify children with blood lead levels below 25 µg/dL.

Initial screening may be done using a capillary specimen if procedures are followed to prevent the contamination of the sample. Consider an elevated blood level from a capillary test presumptive. Confirm it with a venous blood specimen.

For more information or assistance on lead testing, screening, or case management, contact the Bureau of Lead Poisoning Prevention, Iowa Department of Public Health, (515) 281-3479 or (800) 972-2026.

Click [here](#) to access the Iowa Childhood Lead Poisoning Risk Questionnaire. Use this questionnaire to decide whether to use the high risk or low risk blood lead testing schedule, or use the high risk testing schedule for all children. Do **not** assume that all children are at low risk. The lead testing and follow up protocols are also located at this link.

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### **g. Newborn Screening**

Confirm during the infant's first visit that newborn screening was done. In Iowa newborn screening is mandatory for the conditions on the screening panel.

Click [here](#) to view a current list of the screening panel.

### **h. Tuberculin Testing**


The American Academy of Pediatrics Committee on Infectious Disease recommends annual tuberculin skin testing in high-risk children.

High-risk children include those in households where tuberculosis is common (e.g., from Asia, Africa, Central America, the Pacific Islands, or the Caribbean; migrant workers; residents of correctional institutions and homeless shelters; and homes of IV drug users, alcoholics, HIV positives, and prostitutes).

## **3. Physical Examination**

Perform a comprehensive unclothed physical examination at each screening visit. It should include, but is not limited to, the following:

- ◆ General appearance
- ◆ Assessment of all body systems
- ◆ Height and weight
- ◆ Head circumference through 2 years of age
- ◆ Blood pressure starting at 3 years of age
- ◆ Palpation of femoral and brachial (or radial) pulses
- ◆ Breast inspection and palpation for age-appropriate females, including breast self-examination instructions and health education
- ◆ Pelvic examination, recommended for women 18 years old and older, if sexually active or significant menstrual problems
- ◆ Testicular examination, include age-appropriate self-examination instructions and health education

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#### **a. Blood Pressure**

Blood pressure measurement is a routine part of the physical examination at three years of age and older. During infancy, conduct a blood pressure only if other physical findings suggest it may be needed.

The National Health, Lung and Blood Institute published blood pressure standards for children and adolescents. The standards are based on height as well as age and gender for children and adolescents from one through 17 years old.

This is a change from the past when height and weight were both thought to be correlates of blood pressure. Height was determined by the investigators to be a better correlate for children and teenagers because of the prevalence of obesity in young people in this country. The standards appear in the Blood Pressure Tables for Children and Adolescents. See below.

To use the tables, measure each child and plot the height on a standard growth chart. Measure the child's systolic and diastolic blood pressure and compare them to the numbers provided in the tables for blood pressure for height, age, and sex.

The National Heart, Lung and Blood Institute recommends using the disappearance of Korotkoff's (K5) to determine diastolic blood pressure in children and adolescents.

The interpretation of children and adolescents blood pressure measurements for height, age, and gender are as follows:

- ◆ Readings below the 90th percentile are considered normotensive.
- ◆ Reading between the 90th and 95th percentile are high normal and warrant further observation and identification of risk factors.
- ◆ Readings of either systolic or diastolic at or above the 95th percentiles indicate the child may be hypertensive. Repeated measurements are indicated.

Click [here](#) to access Blood Pressure Tables for Children and Adolescents provided by the National Heart, Lung and Blood Institute.



## **b. Growth Measurements**

### **(1) Body Mass Index**

Body Mass Index (BMI) is the recommended parameter for monitoring the growth of children 24 months and older. BMI can be determined using a handheld calculator. The steps for calculating BMI using pounds and inches are listed below.

1. Convert any fractions to decimals.

Examples: 37 pounds 4 ounces = 37.25 pounds  
41½ inches = 41.5 inches

2. Insert the values into the formula:

$[\text{weight (lb.)} / \text{height (in.)} / \text{height (in.)}] \times 703 = \text{BMI}$

Example:  $(37.25 \text{ lb.} / 41.5 \text{ in.} / 41.5 \text{ in.}) \times 703 = 15.2$

A reference table can also be used to calculate BMI. Click [here](#) to download the table from the Centers for Disease Control and Prevention.

For children, BMI values are plotted against age. If the BMI-for-age is less than or equal to the 5th percentile, the child is considered underweight. If the BMI-for-age is between the 85th and 94th percentiles, the child is considered to be at risk for overweight. Children with a BMI equal to or greater than the 95th percentile are considered overweight.

### **(2) Height**

Measure children over 2 years of age using a standing height board or stadiometer.

If the child is two years old or older and less than 31½ inches tall, the height measurement does not fit on the 2-20 year old chart. Therefore, measure the child's recumbent length and plot the length on the Birth-36 month growth chart. Read and record the measurement to the nearest 1/8 inch.

Never use measuring rods attached to scales, because the surface on which the child stands is not stable, and the measuring rod's hinge tends to become loose, causing inaccurate readings.



### (3) Plotting Measurements

Record measurements as soon as they are taken to reduce errors.

Plot weight and height against age and weight against height on the Center for Disease Control and Prevention (CDC) growth chart for the children under 2 years of age. For children 2-20 years, plot weight and height against age and BMI against age on the appropriate growth chart.

Example:

	Year	Month	Day	
<b>Date of visit</b>	<del>93</del> 92	<del>7</del> <del>6</del> 18	<del>45</del> 45	July 15, 1993
<b>Birth date</b>	-91	-10	-28	October 28, 1991
<b>Age</b>	1	8	17	= 20 months, 17 days or 21 months

Borrow 30 days for the 7 in the month column to make the day column 45 and the month column 6.

Borrow 12 months for 93 in the year column so that the top number in the month column is now 18.

Calculate the age to the nearest month. (Round to the next month if over 15 days.) Subtract birth date from the clinic visit date. It is allowable to borrow 30 days from the months column or 12 months for the year column when subtracting.

Common errors result from:

- ◆ Unbalanced scales,
- ◆ Failure to remove shoes and heavy clothing,
- ◆ Use of an inappropriate chart for recording the results, and
- ◆ Uncooperative children.





#### **(4) Recumbent Length**

Measure the length of infants and children up to two years of age on a horizontal length board with a fixed headboard and sliding footboard securely attached at right angles to the measuring surface. Read and record the measurement to the nearest 1/8 inch.

#### **(5) Referral and Follow-up of Growth in Infants and Children**

**Nutrition.** See criteria in [Nutritional Status](#).


**Medical.** Most children follow the usual patterns of growth, but a small but significant number of children have growth patterns that cross percentile lines in infancy, familial short stature, constitutional growth delay, and familial tall stature. Some warning signs of growth abnormalities are as follows:

- ◆ Growth of less than 2 inches per year for ages 3 to 10 years.
- ◆ A greater than 25 percent change in weight/height percentile rank.
- ◆ Sudden weight gain or loss.
- ◆ More than two standard deviations below or above the mean for height.

#### **(6) Weight**

Use a balance beam scale with non-detachable weights. Calibrate the scale once a year. Infants can be measured on either a specially designed infant scale or in a cradle on the adult scale.

Weigh infants and children with a minimal amount of clothing. Read and record to the nearest ounce for infants and quarter of a pound for children and youth.

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### c. Head Circumference

Measure the head circumference at each visit until the child is two years old. Measure with a non-stretchable tape measure firmly placed from the maximal occipital prominence around to the area just above the eyebrow. Plot the results on the Center for Disease and Prevention (CDC) growth chart.

Further evaluation is needed if the CDC growth grid reveals a measurement:

- ◆ Above the 95th percentile.
- ◆ Below the 5th percentile.
- ◆ Reflecting a major change in percentile levels from one measurement to the next or over time.

### d. Oral Health Screening


The purpose of the oral health screening is to identify dental anomalies or diseases, such as dental caries (tooth decay), soft tissue lesions, gum disease, or developmental problems and to ensure that preventive oral health education is provided to the parents or guardians.

Children need an oral screening by the age of 12 months. An oral screening includes a medical and dental history and an oral evaluation. Each component of the oral screening listed below must be documented in the child's record:

- ◆ Complete or update the medical history:
  - Name of child's physician
  - Current medications used
  - Allergies
- ◆ Complete or update the dental history:
  - Name of child's dentist
  - Allergies
  - Frequency of dental visits
  - Parental concerns
  - Use of fluoride by child (source of water, use of fluoridated toothpaste or fluoride products)
  - Current or recent dental problems or injuries, including parental concerns



- Home care (frequency of brushing, flossing, or other oral hygiene practices)
- Exposure to sugar, carbohydrates (snacking and feeding habits, use of sugary medications)
- ◆ Oral evaluation
  - Hard tissue:
    - Suspected decay
    - Demineralized areas (white spots)
    - Visible plaque
    - Enamel defects
    - Sealants
    - Decay history (fillings, crowns)
    - Stained fissures
    - Trauma or injury
  - Soft tissue:
    - Gum redness or bleeding
    - Swelling or lumps
    - Trauma or injury
- ◆ Provide age-appropriate oral health education to the parent or guardian. Education should be based on the findings of the oral health screening.
- ◆ Iowa's EPSDT recommendations for dental care are based on the American Academy of Pediatric Dentistry and Iowa's definition of a dental home found within [Iowa Administrative Code](#). Iowa's dental periodicity recommendations may be seen [here](#).
- ◆ Refer children to a dentist for:
  - Complete dental examination within six months of the eruption of the first tooth or by the first birthday and periodic exams based on risk assessment
  - Obvious or suspected dental caries
  - Pain or injury to the oral tissue
  - Difficulty chewing
- ◆ Through the I-Smile™ Dental Home program, dental hygienists serving as I-Smile™ Coordinators will provide assistance to health care providers and families to help children access early and regular dental care. Contact information for a local I-Smile™ coordinator is available online at: [www.ismiledentalhome.iowa.gov](http://www.ismiledentalhome.iowa.gov)

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#### 4. Other Services

Other services that must be included in the screening examination are:

- ◆ [Immunizations](#)
- ◆ [Hearing screening](#)
- ◆ [Assessment of nutritional status](#)
- ◆ [Vision screening](#)

##### a. Immunization

In an effort to improve immunization practice, the health objectives for the nation call for a minimum of 90% of children to have recommended immunizations by their second birthday.

Standards published by the National Vaccine Advisory Committee in February 2002 reflect changes and challenges in vaccine delivery.


Every time children are seen, screen their immunization status and administer appropriate vaccines. (See [ACIP Recommendations Immunization Schedule](#).) Information about immunizations may be obtained by contacting the CDC at (800) 232-4636 or the Iowa Immunization Program at (800) 831-6293.

Many opportunities to immunize children are missed due to lack of knowledge about true contraindications, such as erroneously considering mild illness a contraindication. See [Contraindications and Precaution for Immunization](#) for a guide to contraindications to immunization.

When multiple vaccines are needed, administer vaccines simultaneously to decrease the number of children lost to follow-up. Do this particularly in high-risk populations who tend to be transient and noncompliant with recommendations for routine health maintenance visits.

Under the leadership of National Vaccine Advisory Committee (NVAC), standards were recently revised. Click [here](#) to view the revised standards which focus on:

- ◆ Making vaccines easily accessible
- ◆ Effectively communicating vaccination information
- ◆ Implementing strategies to improve vaccination rates
- ◆ Developing community partnerships to reach target patient populations

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Provide the recommended childhood immunization schedule for the United States for January-December of the current year. The recommended childhood and adolescent immunization schedule can be assessed on the following websites:

- ◆ [Centers for Disease Control and Prevention: Vaccines and Immunizations](#)
- ◆ [American Academy of Pediatrics](#)
- ◆ [American Academy of Family Physicians](#)

#### **b. Hearing**

Objective screening of hearing for all neonates is now recommended by the Joint Committee on Infant Hearing. Click [here](#) to view recommendations.

Objective hearing screening should be performed on all infants before age one month. Newborn infants who have **not** had an objective hearing test should be referred to an audiologist who specializes in infant screening using one of the latest audiology screening technologies.

Infants who do not pass the initial hearing screen and the subsequent rescreening should have appropriate audiology and medical evaluations to confirm the presence of hearing loss before three months.

All infants with confirmed hearing loss should receive intervention services before six months of age.

For information on nearby audiologists, see the early hearing detection and intervention system (EDHI) website, click [here](#) or call (888) 425-4371.

An objective hearing screening should be performed on all infants and toddlers who do not have a documented objective newborn hearing screening or documented parental refusal. This screening should be conducted by a qualified screener during well-child health screening appointments according to the periodicity schedule.



An objective hearing screening performed on newborns and infants will detect congenital hearing loss, but will not identify those children with late onset hearing loss. In order to be alert to late onset hearing loss, health providers should also monitor developmental milestones, auditory and speech skills, middle ear status, and should consider parental concerns.

A child of any age who has not had objective hearing screening should be referred for audiology evaluation to rule out congenital hearing loss.

The following risk indicators are associated with either congenital or delayed-onset hearing loss. Heightened surveillance of all children with risk indicators is recommended. Risk indicators marked with an asterisk are greater concern for delayed-onset hearing loss.

- ◆ Caregiver concern<sup>\*</sup> regarding hearing, speech, language, or developmental delay (Roizen, 1999).
- ◆ Family history<sup>\*</sup> of permanent childhood hearing loss (Cone-Wesson et al., 2000; Morton & Nance, 2006).
- ◆ Neonatal intensive care of more than five days or any of the following regardless of length of stay:
  - Extracorporeal Membrane Oxygenation (ECMO)<sup>\*</sup>
  - Assisted ventilation
  - Hyperbilirubinemia requiring exchange transfusion
  - Exposure to ototoxic medications (gentamycin and tobramycin) or loop diuretics (furosemide/lasix)(Fligor et al., 2005; Roizen, 2003)
- ◆ In-utero infections, such as CMV,<sup>\*</sup> herpes, rubella, syphilis, and toxoplasmosis (Fligor et al., 2005; Fowler et al., 1992; Madden et al., 2005; Nance et al., 2006; Pass et al., 2006; Rivera et al., 2002).
- ◆ Craniofacial anomalies, including those involving the pinna, ear canal, ear tags, ear pits, and temporal bone anomalies (Cone-Wesson et al., 2000).
- ◆ Physical findings, such as white forelock, associated with a syndrome known to include a sensorineural or permanent conductive hearing loss (Cone-Wesson et al., 2000).



- ◆ Syndromes associated with hearing loss or progressive or late-onset hearing loss, \* such as neurofibromatosis, osteopetrosis, and Usher syndrome (Roizen, 2003). Other frequently identified syndromes including Waardenburg, Alport, Pendred and Jervell and Lange-Nielson (Nance, 2003).
- ◆ Neurodegenerative disorders, \* such as Hunter syndrome, or sensory motor neuropathies, such as Friedreich ataxia and Charcot-Marie-Tooth syndrome (Roizen, 2003).
- ◆ Culture-positive postnatal infections associated with sensorineural hearing loss, \* including confirmed bacterial and viral (especially herpes viruses and varicella) meningitis (Arditi et al., 1998; Bess, 1982; Biernath et al., 2006; Roizen, 2003).
- ◆ Head trauma, especially basal skull/temporal bone fracture \* requiring hospitalization (Lew et al., 2004; Vartialnen et al., 1985; Zimmerman et al., 1993).
- ◆ Chemotherapy \* (Bertolini et al., 2004).

**Source:** [\*Hearing Screening Bright Futures, Guidelines for Health Supervision of Infants, Children, and Adolescents, Third Edition.\*](#)

### c. **Nutritional Status**

To assess nutritional status, include:

- ◆ Accurate measurements of height and weight.
- ◆ A laboratory test to screen for iron deficiency anemia (see Hgb/Hct procedures under [Hemoglobin and Hematocrit](#) for suggested screening ages).
- ◆ Questions about dietary practices to identify:
  - Diets that are deficient or excessive in one or more nutrients.
  - Food allergy, intolerance, or aversion.
  - Inappropriate dietary alterations.
  - Unusual eating habits (such as extended use of bottle feedings, pica, or abnormal behaviors intended to change body weight).
- ◆ Complete physical examination, including dental, with special attention to such general features as pallor, apathy, and irritability.



- ◆ If feasible, cholesterol measurement for children over two years of age who have increased risk for cardiovascular disease according to the following criteria:
  - Parents or grandparent, at 55 years of age or less, underwent diagnostic coronary arteriography and was found to have coronary atherosclerosis or suffered a documented myocardial infarction, peripheral vascular disease, cerebrovascular disease, or sudden cardiac death.
  - A parent who has been found to have high blood cholesterol (240 mg/dL or higher).

### **(1) Medical Evaluation Indicated (0-12 months)**

Use the following criteria for referring an infant for further medical evaluation due to nutrition status:

- ◆ Measurements
  - Weight/height < 5th percentile or > 95th percentile (NCHS charts)
  - Weight/age < 5th percentile
  - Major change in weight/height percentile rank (a 25 percentile or greater shift in ranking)
  - Flat growth curve (two months without an increase in weight/age of an infant below the 90th percentile weight/age)
- ◆ Laboratory tests
  - < Hct 32.9%
  - < Hgb 11 gm/dL (6-12 months)
  - $\geq 15$   $\mu$ g/dL blood lead level
- ◆ Health problems
  - Metabolic disorder
  - Chronic disease requiring a special diet
  - Physical handicap or developmental delay that may alter nutritional status
- ◆ Physical examination: Abnormality of any of the following which indicates poor nutrition: hair, skin or nails, eyes, teeth or gums, disorders of the thyroid or parotid glands, gastrointestinal disorders, neurological disorders, or skeletal disorders





## (2) Medical Evaluation Indicated (1-10 years)

Use these criteria for referring a child for further medical evaluation of nutrition status:

### ◆ Measurements

- Weight/length < 5th percentile or > 95th percentile for 12-23 months
- BMI for age < 5th percentile or > 95th percentile for 24 months and older
- Weight/age < 5th percentile
- Major change in weight/height percentile rank (a 25 percentile or greater shift in ranking)
- Flat growth curve:

Age	Indicator
12 to 36 months	Two months without an increase in weight per age of a child below the 90th percentile weight per age.
3 to 10 years	Six months without an increase in weight per age of a child below the 90th percentile weight per age.

### ◆ Laboratory tests

Age	HCT %	HGB gm/dL
1 up to 2 years	32.9	11.0
2 up to 5 years	33.0	11.1
5 up to 8 years	34.5	11.4
8 up to 10 years	35.4	11.9

### ◆ Health problems

- Chronic disease requiring a special diet
- Metabolic disorder
- Family history of hyperlipidemias
- Physical handicap or developmental delay that may alter nutritional status

- ◆ Physical examination: Abnormality of any of the following which indicates poor nutrition: hair, skin or nails, eyes, teeth or gums, disorders of the thyroid or parotid glands, gastro-intestinal disorders, neurological disorders, or skeletal disorders



### (3) Medical Evaluation Indicated (11-21 years)

Use these criteria for referring adolescents for further medical evaluation of nutritional status:


◆ Laboratory tests

Age	Female		Male	
	HCT %	HGB gm/dL	HCT %	HGB gm/dL
11 up to 12	35.4	11.9	35.4	11.9
12 up to 15	35.7	11.8	37.3	12.5
15 up to 18	35.9	12.0	39.7	13.3
18 up to 21	35.7	12.0	39.9	13.6

◆ Health problems

- Chronic disease requiring a special diet
- Physical handicap or developmental delay that may alter nutritional status
- Metabolic disorder
- Substance use or abuse
- Family history of hyperlipidemias
- Any behaviors intended to change body weight, such as self-induced vomiting, bingeing and purging, use of laxatives or diet pills, skipping meals on a regular basis, excessive exercise
- Physical examination. Abnormality of any of the following which indicates poor nutrition: hair, skin or nails, eyes, teeth or gums, disorders of the thyroid or parotid glands, gastrointestinal disorders, neurological disorders, or skeletal disorders

**Source:** *Expert Panel on Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents.*  
U.S. Department of Health and Human Services, October 2012.

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#### **d. Vision**

Examination of the eyes should begin in the newborn period and should be done at all well infant and well child visits. Comprehensive examination of children is recommended as a part of the regular plan for continuing care beginning at three years of age.

At each visit, obtain a history to elicit from parents evidence of any visual difficulties. During the newborn period, infants who may be at risk for eye problems include those who are premature (e.g., retinopathy of prematurity) and those with family history of congenital cataracts, retinoblastoma, and metabolic and genetic diseases.

Click [here](#) to view the full scope of pediatric vision screening as stated by the American Academy of Ophthalmology Pediatric Ophthalmology/Strabismus Panel.

#### **D. BASIS OF PAYMENT**

Payment to a screening center for services is on a fee-for-service basis. Submit all the actual costs of the screening examination, lab tests, and immunizations.

Click [here](#) to view the fee schedule for Screening Centers.

Bill all procedures in whole units of service. For most codes, 15 minute equals one unit. Round remainders of seven minutes or less down to the lower unit and remainders of more than seven minutes up to the next unit.

#### **E. RECORDS**

The documentation for each "patient encounter" shall include the following (when appropriate):

- ◆ Complaint and symptoms; history; examination findings; diagnostic test results; assessment, clinical impression or diagnosis; plan for care; date; and identity of the observer
- ◆ Specific procedures or treatments performed
- ◆ Medications or other supplies
- ◆ Patient's progress, response to and changes in treatment, and revision of diagnosis



- ◆ Information necessary to support each item of service reported on the Medicaid claim form:
  - Date of service
  - Place of service
  - Name of member
  - Name of provider agency and person providing the service
  - Nature, content, or units of service. Maintain a record of the time to support the units on the claim form. (Time must include AM/PM.)

Documentation of medical transportation services shall include the following:

- ◆ Date of service
- ◆ Member's name
- ◆ Address of where member was picked up
- ◆ Destination (medical provider's name and address)
- ◆ Invoice of cost
- ◆ Mileage if the transportation is paid per mile

Providers of service shall maintain fiscal records in support of each item of service for which a charge is made to the program. The fiscal record does not constitute a clinical record.

Failure to maintain supporting fiscal and clinical records may result in claim denials or recoupment of Medicaid payment.


As a condition of accepting Medicaid payment for services, providers are required to provide the Iowa Medicaid program access to client medical records when requested. Providers shall make the medical and fiscal records available to the Department or its duly authorized representative on request.

## **F. PROCEDURE CODES AND NOMENCLATURE**

Medicaid recognizes Medicare's National Level II Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes. However, all HCPCS and CPT codes are not covered.

Refer to the current fee schedule for a listing covered of codes.

Providers who do not have Internet access can obtain a copy upon request from the IME.

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It is your responsibility to select the code that best describes the item dispensed. Claims submitted without a procedure code will be denied. Refer coverage questions to the IME.

### New Patient

- 99381 **Initial preventive medicine** evaluation and management of an individual including a comprehensive history, a comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate laboratory/diagnostic procedures, new patient; infant (age under 1 year)
- 99382 Early childhood (age 1 through 4 years)
- 99383 Late childhood (age 5 through 11 years)
- 99384 Adolescent (age 12 through 17 years)
- 99385 18-20 years

### Established Patient

- 99391 **Periodic preventive medicine** reevaluation and management of an individual including a comprehensive history, a comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate laboratory/diagnostic procedures, established patient; infant (age under 1 year)
- 99392 Early childhood (age 1 through 4 years)
- 99393 Late childhood (age 5 through 11 years)
- 99394 Adolescent (age 12 through 17 years)
- 99395 18-20 years

Use the following modifier if applicable:


#### **Modifier**    **Description**

- U1      Indicate a referral for treatment

If a follow-up visit is scheduled after the preventive visit, use the following codes and an appropriate ICD-10 code.

#### **Code**      **Description**

- 99211      Office or other outpatient visit for the evaluation and management of an established patient.

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## 1. Home Visits

<u>Code</u>	<u>Description</u>
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S9123	Nursing visit in the home, per hour
S9127	Social work visit in the home (encounter code)

Use the appropriate ICD-10 diagnosis code.


## 2. Interpretation Services

<u>Code</u>	<u>Description</u>	<u>Unit</u>
T1013	Sign language or oral interpretative services	15 minute unit
T1013	Telephonic oral interpretive services	1 minute unit
UC		

## 3. Local Transportation

Only agencies designated by the Iowa Department of Public Health can bill for transportation services. In the diagnosis area of the claim form, use diagnosis code Z76.89.

<u>Code</u>	<u>Description</u>	<u>Unit</u>
A0110	Non-emergency transportation and bus, intrastate or interstate carrier	Per round trip
A0100	Non-emergency transportation taxi – intercity	Per round trip
A0130	Non-emergency transportation; wheelchair van	Per round trip
A0090	Non-emergency transportation per mile – volunteer interested individual, neighbor	Per mile
A0120	Non-emergency transportation mini-bus, mountain area transports, other non-profit transportation systems	Per round trip
A0170	Transportation, parking fees, tolls, other	

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#### 4. Nutritional Counseling

Payment for nutritional counseling services will be made using the following codes:

<b><u>Code</u></b>	<b><u>Description</u></b>
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97803	Reassessment and intervention, individual, face-to-face with the patient, each 15 minutes

In the diagnosis area of the claim form, use the diagnosis appropriate for the condition being treated.

#### 5. Oral Health Services

Payment for oral health services will be made using the following procedure codes along with the appropriate ICD-10 diagnosis codes. Use the TD modifier, in addition to those codes listed below, when an allowable service is provided by a nurse.

<b><u>Code</u></b>	<b><u>Mod</u></b>	<b><u>Procedure</u></b>	<b><u>Comment</u></b>
D0120		Periodic screening evaluation by dentist	Once every six months
D0145*	DA	Oral evaluation for patient under age three and counseling with primary caregiver	Once every six months
D0150		Initial screening evaluation by dentist	One time per patient (Also allowed when provider has not seen patient within three years)
D0190*	CC	Initial screening by a non-dentist	One time per patient (Also allowed when provider has not seen patient within three years)
D0190*		Periodic screening by a non-dentist	Once every six months




<u>Code</u>	<u>Mod</u>	<u>Procedure</u>	<u>Comment</u>
D0270		Bitewing, single film **	Once every 12 months
D0272		Bitewing, two films **	Once every 12 months
D0274		Bitewing, four films **	Once every 12 months
D0601*		Caries risk assessment and documentation, with a finding of low risk	Oncer every 6 months
D0602*		Caries risk assessment and documentation, with a finding of moderate risk	Oncer every 6 months
D0603*		Caries risk assessment and documentation, with a finding of high risk	Oncer every 6 months
D1110		Adult prophylaxis (age 13 and older)	Once every six months
D1120		Child prophylaxis (age 12 and younger)	Once every six months
D1206		Topical fluoride varnish	Four times per year, at least 90 days apart
D1310		Nutritional counseling for the control and prevention of oral disease	15-minute unit once every six months
D1330		Oral hygiene instruction	15-minute unit once every six months
D1351		Sealant, per tooth	One time per tooth ages 6-18 (Replacement sealants may be covered when record documents medical necessity)

\* Services provided by a nurse must include the TD modifier.

\*\* Before radiographs are taken, standing orders must be in place with a specific dentist who will read the radiographs, provide an examination, and establish a treatment plan.




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## 6. Testing

Bill specific laboratory and testing services as follows:

<u>Code</u>	<u>Description</u>
36416	Collection of capillary blood specimen (e.g., finger, heel, ear stick) (Cannot be used in conjunction with 99000.)
36415	Collection of venous blood by venipuncture (Cannot be used in conjunction with 99000)
99000	Handling or conveyance of specimen for transfer to a lab (Cannot be used with any other code)
85014	Hematocrit
85018	Hemoglobin
83655	Lead
92555	Speech audiometry (threshold only)
86580	Tuberculosis, intradermal
81002	Urinalysis
99173	Visual acuity (will not be paid if used with the preventive visit code)
99408	Alcohol and/or substance abuse structured screening and brief intervention (15 to 30 minutes)
99409	Alcohol and/or substance abuse structured screening and brief intervention (greater than 30 minutes)
99420	Administration and interpretation of health risk assessment  <b>NOTE:</b> Used for caregiver depression screening, caregiver or adolescent domestic violence screening, and caregiver alcohol and/or substance abuse screening. Caregiver must be over age 21.
G0444	Annual depression screening
G0451	Developmental testing with interpretation and report per standardized instrument form
96127	Brief emotional or behavioral assessment with scoring and documentation, per standardized instrument
H0031	Mental health assessment by non-physician
G0442	Annual alcohol misuse screening, 15 minutes
H0049	Alcohol and/or drug screening

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## 7. Vaccinations

You must provide Medicaid immunizations under the Vaccines for Children Program (VFC). Click [here](#) to view the list of vaccines available through the VFC program or call (800) 831-6293.

When a student receives a vaccine outside of the VFC schedule, Medicaid will provide reimbursement.


For VFC vaccine, bill code 90460, 90461, 90471, 90472, and 90473 for vaccine administration in addition to the CPT code for the vaccine. The charges in box 24F should be "0." Charge your cost for 90460, 90471, 90472, or 90473. Code 90461 is not reimbursed but used for information purposes.

**NOTE:** Procedure code 90473 cannot be reported in conjunction with procedure code 90471.

Procedure codes 90460 and 90461 can also be used. There will not be a payment for 90461, but it is collected for informational purposes.

If a follow-up visit is scheduled after the preventive visit, use the following codes and an appropriate ICD code:

<b><u>Code</u></b>	<b><u>Description</u></b>
90460	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component
90461	Each additional vaccine/toxoid component (List separately in addition to code for primary procedure.) (Use 90460 for each vaccine administered. For vaccines with multiple components (combination vaccines), report 90460 in conjunction with 90461 for each additional component in a given vaccine.)
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid) (Do not report 90471 in conjunction with 90473.)
90472	Each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure.) (Use 90472 in conjunction with 90471 or 90473.)

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<u>Code</u>	<u>Description</u>
90473	Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid) (Do not report 90473 in conjunction with 90471.)
90474	Each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure.) (Use 90474 in conjunction with 90471 or 90473.)

## 8. Other

<u>Code</u>	<u>Procedure</u>	<u>Comment</u>
T1001	Nursing assessment/evaluation	Encounter code
G0443	Brief face-to-face behavioral counseling for alcohol misuse	15 minutes
G0447	Face-to-face behavioral counseling for obesity	15 minutes
H0046	Mental health services, not otherwise specified	Encounter code
99401	Preventive medicine counseling	15 minutes
99402	Preventive medicine counseling	30 minutes

## G. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

Claims for Screening Centers are billed on federal form CMS-1500, *Health Insurance Claim Form*.

Click [here](#) to view a sample of the CMS-1500.

Click [here](#) to view billing instructions for the CMS-1500.

Refer to [Chapter IV. Billing Iowa Medicaid](#) for claim form instructions, all billing procedures, and a guide to reading the Iowa Medicaid Remittance Advice statement.